80 Mary Street,
Clinton ON, N0M1L0
T: 519-606.7777
F:519.606.7750
Dr.'s Caitlin Lubberdink &
Mitch Badz

# THE CHIROPRACTIC HOUSE & CO,
# New Patient Paperwork- Child (0-4 years)

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with form, please do not hesitate to ask one of our Chiropractic Health Assistants.

Date _____

**Personal Information**

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: (_____)_____ Birth date: ____/____/____(mm/dd/yy) ❑ Male ❑ Female ❑Undisclosed
Parents Occupation: _____ Business / Employer: _____
Business Phone: (_____)_____ Extended Health Coverage: _____
Mother & Father Names _____ Siblings Names & Ages _____
Mobile Phone: (_____)_____ Name of Emergency Contact: _____
Emergency Contact's Relationship: _____ Phone Number For Emergency Contact: (_____)_____
Referred To This Office By: ❑ Yellow Pages ❑ Website ❑ RMT ❑ Patient/Dr. (name): _____
Email Address: _____

**Please check the phrase that most represents your reason for child's care:**
❑ Wellness ❑ Prevention ❑ Feel good ❑ Symptom Relief

**Current Health Information**

*If this child has **no complaints** and this exam is for a spinal wellness check-up, **please skip to section** on the next page marked with* ***PAST MEDICAL HISTORY**

Current complaint(s) _____

When did this condition begin? _____ Has this occurred before? ❑ No ❑ Yes

What aggravates the child's condition(s)? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting
❑ Walking ❑ Sleeping ❑ Other _____

What relieves the child's condition? ❑ Ice ❑ Heat ❑ Massage ❑ Stretches
❑ Bed Rest ❑ Walking ❑ Medication
❑ Other _____

Is this condition becoming ❑ Worse ❑ Better ❑ Constant ❑ Comes & Goes

Have you seen other doctors/therapists seen for this condition? ❑ No ❑ Yes Who? _____

How does this condition affect the Childs
❑Ability to sleep ❑ Ability to Eat. ❑Behaviour. ❑ Ability to Play

## ❑Past Medical History**

Name of this child's Medical Doctor/Town _____

Date of last physical examination _____

Does this child currently take any medications ❑ No ❑ Yes _____

Does this child currently take any natural supplements ❑ No ❑ Multivitamins ❑ Other _____

Is this child currently breastfeeding/ was the child previously breast fed? ❑ Yes ❑ No ❑ Formula

Has your child had any issues with-
❑ Feeding ❑ Indigestion/Constipation and gas ❑ Inconsolable crying and mood ❑ Back arching or seeming discomfort.
❑ Favouring head turn to one side
If Yes- please elaborate_____

What is your personal satisfaction with this child's diet?
❑ Highly Satisfied ❑ Satisfied ❑ Dissatisfied ❑ Highly Dissatisfied

Please rate the quality of this child's sleep: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Number of sleeping hours at night: _____ Number of napping hours during the day:_____

Does this child suffer from any other health conditions? ❑ No. ❑ Yes _____

**History of Birth**

Birth Weight: _____ Birth Length: _____ Position at birth:_____

Arrival Time: ❑ Premature ❑ Term (40 weeks) ❑ Post Term- _____weeks
Any Intervention used: ❑ Forceps ❑ Vacuum Extraction. ❑ Manual Pulling by Doctor/Midwife ❑ Epidural
Type of Birth: ❑Vaginal ❑ C Section
Duration of Labour: _____
Issues during pregnancy including: : ❑ Fall on buttocks ❑ Hypertension ❑ Gestational Diabetes ❑ Low Back pain

Apgar Scores (if Known) _____ _____
At birth, was there presence of Jaundice(yellow)_____ OR Cyanosis (blue)_____

**Milestones:**
At what age did your child:
Hold up head _____ Sit alone _____
Crawl _____ Stand _____
Walk alone _____

**Past History Traumas**
Please note any injuries below- with the approximate year and any details.

Major traumas/falls: _____
Birth Injuries: _____
Surgeries: _____

Has this child ever been to a Chiropractor before? ❑ No ❑ Yes
Is there any family history of scoliosis? ❑ No. ❑ Yes, please list relation _____

**Informed Consent to Examination & First Treatment.**

As with any medical procedure your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have your child examined and treated by one of the Chiropractors at the Chiropractic House & Co. The purpose of this examination is to determine the cause of any health problems that your child may be experiencing. The examination also allows the doctor named above to determine what the best course of treatment would be in your child's individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your child's spine and extremities, intra-oral exam, various orthopedic and neurological tests, and palpation of your child's joints and muscles using our hands. The chiropractic examination is a "hands-on" approach so that we can best assess your child's health. If a problematic area is identified during the exam it will be communicated with the caregiver and typically treatment will be applied immediately with oral consent from the caregiver to help avoid prolonging the appointment for the little one. At the second visit we will go through full details and an additional consent with the caregiver and explain the proper plan of management and recommendations depending on the unique case.

**Office Policies** *Please Initial Below*

_____I agree to the DC's discussing with other health practitioners at the Chiropractic House &co. regarding my health concerns related to my chief complaint.
_____I agree to DC's releasing proof of attendance and payment information to 3rd party benefit and insurance companies.

_____
Baby/Toddler's Name

_____ _____ _____
Parent Name Parent Signature Date

_____ _____ _____
Witness Name Witness Signature Date